TASC

Technical Assistance and Services Center

Flex Program Hour Highlights

Date: February 23, 2000
Topic: Network Development
Facilitator: Terry Hill, TASC
Technical Advisors: Dan Campion, Alpha Center
Tony Wellever, Delta Rural Health

Terry Hill opened the meeting by acknowledging the definition of "network" varies from person to person and state to state. He cited the definition of "rural health network" from the BBA as "an organization consisting of at least one CAH and at least one full-service hospital, the members of which have entered into certain agreements regarding patient referral and transfer, communications, and patient transportation."

Tony Wellever of Delta Rural Health (651-646-2660 or twellever@worldnet.att.net) noted that due to the BBRA's change to a 96-hour *average* LOS, there is less incentive for CAHs to develop network relationships. This change may cause fewer transfers between facilities and, therefore, fewer opportunities to build relationships and trust. CAHs may be less likely to re-examine their mission in the community and may only be in "paper compliance" with network development guidelines.

Two types of networks Tony suggested as appropriate models for CAHs are: (1) Networks between CAHs and larger hospitals; and (2) networks within communities. This second definition involves "integration" of services (hiring physicians and non-physicians, adding retail pharmacy services, cooperating with public health, mental health, and dental providers). Integration begins with the proximity issue. Just being close to one another allows facilities to share resources and communicate more freely.

According to Tony, network development in CAHs would be facilitated by:

- Anti-trust protection for rural health networks;
- Grant monies after the first year of CAH conversion for network development; and
- Education to staff and Board about network building.

Dan Campion from the Alpha Center (202-296-1818 or campion@ac.org or www.ac.org) noted that many rural hospitals are already networking with larger hospitals, sometimes with facilities further away than the nearest large hospital. Networking is 90% relationship development and both sides must benefit from the relationship. Small hospitals might need support in administrative issues, recruitment and retention, human resources, etc. The larger hospital is usually looking for referrals from physicians at the smaller hospitals.

Through their *Networking for Rural Health* project, the Alpha Center fosters the development of rural health networks. In order to be eligible for financial and technical assistance from this program, a network must have a formal structure, with explicit goals and purposes, and consist of three or more participants, 50% in rural areas. There are over 200 networks that already exist.

A discussion ensued regarding the common components of failed networks. Two main reasons were cited:

- Many networks were formed in 1994-97 by groups of providers in reaction to the managed care "crisis." Many have failed due to lack of momentum, rather than conflicts within the membership. Effective leadership, vision and support must exist to sustain networks.
- Financial sustainability is another key problem. Many networks are funded by grants and can't become self-sustaining after the grant period ends. It is important to decide very early how to become self-sustaining.

Additional information/resources on network development can be found by visiting the following web sites:

- University of MN Rural Health Research Center at www.hsr.umn.edu/rhrc/ (Minnesota has done a significant amount of rural network research)
- ORHP at www.nal.usda.gov/orhp/
- RICHS at www.nal.usda.gov/ric/richs/.

Terry Hill reported that the National Rural health Resource Center (218-720-0700 or nrhrc@ruralcenter.org) has numerous network development resources, as well as a listing of technical consultants that can help with these activities. He invited states to access the TASC for information and assistance.